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CENTER for INTEGRATED
HEALTH SOLUTIONS

**Implementing
Team Based Care
Innovation Community**

Jeff Capobianco, PhD
National Council for Behavioral Health

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Setting the Stage: Today's Moderator



Madhana Pandian
Senior Associate

SAMHSA-HRSA Center for Integrated Health Solutions

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**Slides for today's webinar will
be available on the CIHS
website:**

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**Under About Us/
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To participate

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Disclaimer: The views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services (CMHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA), or the U.S. Department of Health and Human Services (HHS).


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Setting the Stage



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**Optimizing Health Care
Teams for Improved
Outcomes:**

Tools for Teams of Today
(and Tomorrow)

SAMHSA
Substance Abuse and Mental Health Services Administration
www.samhsa.gov 1-877-SAMHSA-7 (1-877-726-4727)

HRSA
Health Resources & Services Administration

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HMS Center for Primary Care: Systems Transformation



Lindsay Hunt MEd
Program Director



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Practice Transformation
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Call Objectives

- Learn about the Practice Improvement Team model and how it catalyzes and sustains innovation.
- Learn about tools and strategies for effective integration of inter-professional and interdisciplinary members to extended primary care teams.
- Identify at least two tools to test at your organization after today's call.

Agenda

- Introductions and objectives (15 min)
- Six+ key principles for all teams (20 min)
- Practice Improvement Team design (20 min)
- Discussion (20 min)
- Wrap-up (5 min)



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“We cannot live for ourselves alone. Our lives are connected by a thousand invisible threads, and along those sympathetic fibers, our actions run as causes and return to us as results.”



– Herman Melville

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Harvard Medical School Center for Primary Care: Programs & Research on Teams



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*At the Center, our mission is
to transform primary care.
We envision high value health
systems built on a strong
foundation of primary care.*



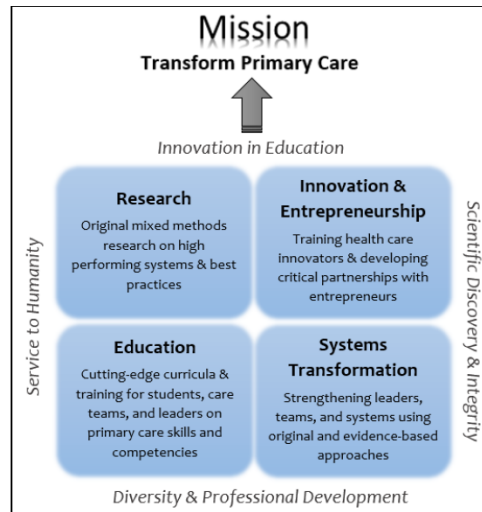
Focused on research, education, systems transformation, and innovation and entrepreneurship



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Strategic Plan and Future Vision



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Systems Transformations Programs

- Academic Innovations Collaborative (AIC)
- Academic Innovations CARES Collaborative (AIC CARES)
- Mental Health Integration Collaborative
- Primary Care Improvement Network
- Advancing Teams in Community Health Program (HRSA)

AIMS of the Academic Innovations Collaborative

- ✓ Building teams
- ✓ Building quality improvement capacity
- ✓ Strengthening practice leadership
- ✓ Improving safety



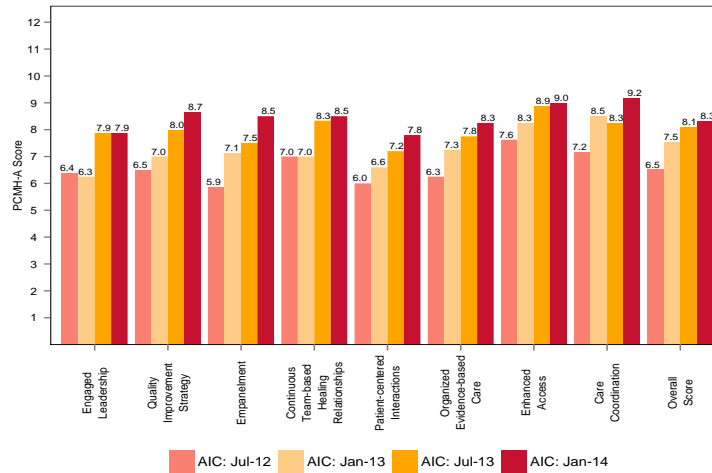
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Foundational Framework



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Results of PCMH-A



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Econometric Estimates (2+ comorbidities)

Type of Utilization	Average Number of Encounters per Thousand Member Months at Baseline	Effect in Units of Utilization per Thousand Member Months	Effect as a % of Intervention Baseline Relative to Controls	p-value
Outpatient Visit*	39.3	-2.2	-5.6%	0.03
Emergency Room (ER) Visit*	33.8	-2.5	-7.4%	0.01
Inpatient Hospitalization	13.6	-0.3	-2.2%	0.80
Ambulatory-Sensitive Condition (ASC) ER Visit	9.7	-1.7	-17.5%	0.10
ASC Inpatient Hospitalization	4.9	-0.8	-16.3%	0.44
Total Cost of Care (in \$ pmpm)	\$1,074.73	\$425.16	40%	0.52

Estimates correspond to difference-in-difference in utilization comparing 2011-2012 to 2014-2015. Models include age, sex, months of enrollment, an Elixhauser Index, year, and an indicator for AIC practice. Generalized linear models account for clustering at the practice level.

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Changes in Patient Experience

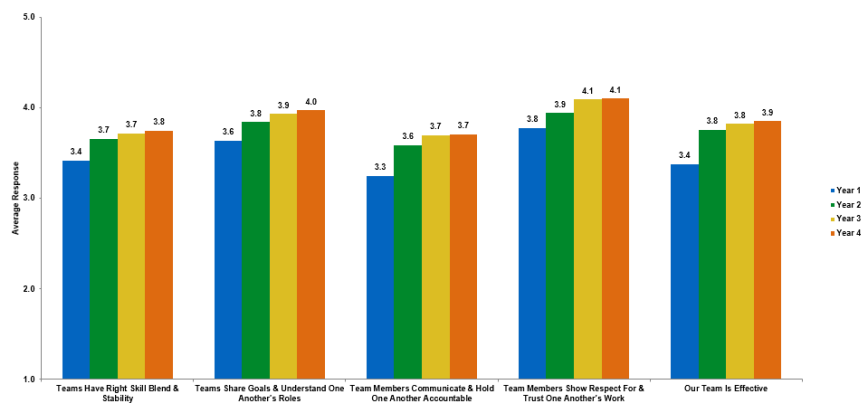
Measure	AIC (Pre)	Control (Pre)	AIC (Post)	Control (Post)	Difference-in-difference
Communication	93.97	94.28	95.46	94.13	1.64**
Integration	86.65	86.94	87.32	86.10	1.51
Knowledge	88.60	88.64	90.55	87.90	2.69***
Access	79.82	80.86	78.24	80.48	-1.20
Staff	86.71	85.48	87.67	87.32	-0.88
Recommend	90.09	90.19	91.89	90.07	1.92*

*p<0.1, ** p<0.05, *** p<0.01

Note: Authors' estimates using MHQP Patient Experience Survey of primary care patients in Massachusetts.

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Changes in Staff Views of Team Dynamics



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Outgrowths of AIC

- Primary Care Improvement Network
- Advancing Teams in Community Health
- Medical Director Leadership Program
- Abundant Health



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Team Starter Kit: 6 Key Steps



1. “If you build it...” Create your team (and structures to support it)

- Obvious but overlooked
- Frequent, regular meeting times
- Space (and the lack of it)
- Engaging leadership



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Huddles



WHY:

- Person-centered integrated care
- Health and well-being
- Value-based reimbursement
- Team-based care
- Population health management

WHAT:

- Brief meetings to plan
- Clarify who will lead the team, project, PDSA, etc.
- Open lines of communication among team members
- Set the tone for the upcoming task
- Establish the protocols, responsibilities, and expected behaviors
- Prepare the team for the task
- Specify expectations

2. True North: Set a Clear Purpose

- All teams need to have a reason for being that is clear to all on the team
- Charter with measures
- Visual cues
- Clearly define boundaries



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Charter Example

AIM: What are we trying to accomplish?		
85% of patients seen on ROSE Team (Behavioral Health Department within Community Health Center) with a diagnosis of hypertension will have BP controlled <140/90 by August 1, 2018.		
Executive Sponsor:		
Project Leader:		
Team Members	Area of Expertise/Role	Email
	Peer Wellness Coach	
	BH Lead	
	Community Health Worker	
	Clinical Assistant	
	Family Physician	
	Family Nurse Practitioner	
	MSW 2 nd Year Intern	
	BSW Intern	
Outcome measures:		Process measures:
Primary measure:		Primary measure:
% of patients seen on ROSE Team over the last year with a diagnosis of HTN with BP controlled <140/90		# Patients with HTN with RN, CHW, Peer, and BH visits related to HTN (will enumerate each type of visit)
Scope:		
We will implement our quality improvement initiatives on ROSE Team, the reverse co-located team at the Community Health Center. This team is located on-site within the health center's BH department and is focused on providing primary care to patients who identify the BH department as their "health home." The population we are targeting are patients with a serious mental health illness, as defined by SAMHSA. The goal is to treat existing HTN among this population and increase screening within this population for more accurate diagnoses of HTN. By collaborating with Chief Performance Improvement Officer, we hope to develop shared treatment plan tools that can then be implemented across CHC.		

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3. Create and Maintain Role Clarity



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4. Promote Clear and Effective Communication

Norms of Collaboration

Each team decided on the rules of the road, or how to work together. These 'rules of the road' are guidelines for how the team wants to handle each of the questions below. It is not meant to be a precise, step-by-step method.

Ask your PIT team about their norms of collaboration!

	Always Do	Never Do
How will we discuss ideas and options?		
How will we make decisions?		
How will we respect each other's time with respect to deadlines?		
How will we schedule and run our meetings?		
How will we assign responsibilities for tasks and follow through on our commitment?		
What are our expectations for meeting preparation and attendance?		
How will we communicate with each other?		
How will we transfer information?		
How will the team foster and manage constructive conflict?		

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4. Clear and Effective Communication (continued)

- Establish well-defined processes for decision making
- Create conditions for healthy conflict and disagreement
- Use SBAR (Situation, background, assessment, recommendation)
- Ensure balanced participation

**JARGON
ALERT!!!**

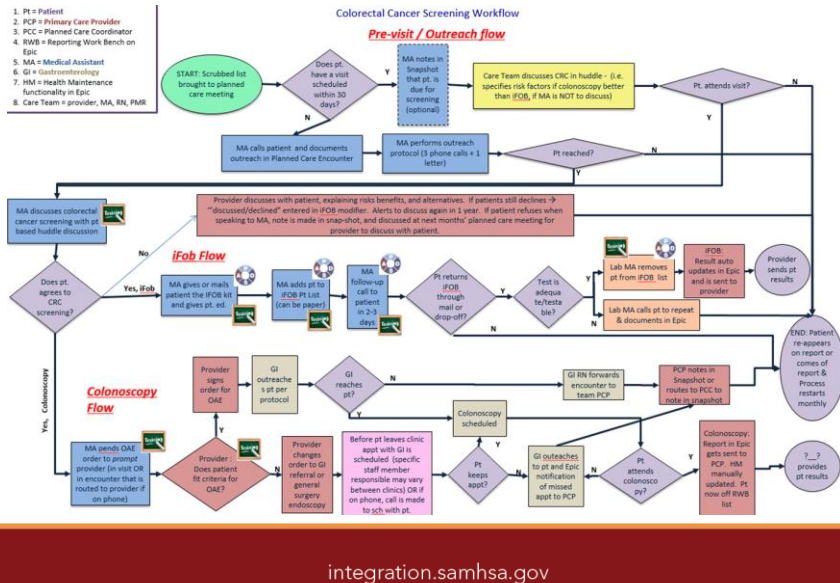
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5. Create and Nurture Culture of Learning and Improvement

- Improvement methodologies: Model for Improvement, Lean, Six Sigma
- Data (run charts, etc.) as tool to build will within and across your team.
- Importance of psychological safety and trust

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Model for Improvement & Process Maps



6. Last (not least)...Start with Yourself

- Value of individual assessment tools
- PCMH-A, Team assessment tools (Singer Teamness survey)
- DISC, MBTI, Five Dynamics



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Team Starter Kit...

1. Build it and support it
2. Set a clear purpose for why it exists
3. Create and maintain role clarity
4. Promote clear and effective communication
5. Create and nurture culture of learning and improvement
6. Start (and end) with yourself

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Discussion

- Think about a current challenge you are facing related to building teams.
- What is one principle or concept that might help address this challenge?

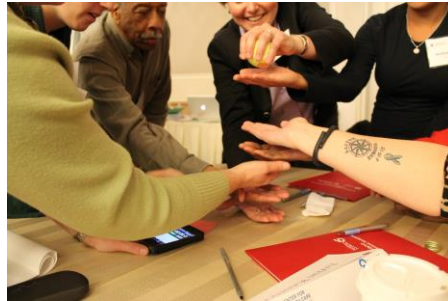


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Practice Improvement Team:

The Heart of Quality Improvement at the Practice Level



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PCMH Change Concepts



Wagner EH, Coleman K, Reid RJ, Phillips K, Abrams MK, Sugarman JR. The Changes Involved in Patient-Centered Medical Home Transformation. *Primary Care: Clinics in Office Practice*. 2012; 39:241-259.

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Practice Improvement Team Definition

Cambridge Health Alliance Practice Improvement Team (PIT):

“As a performance improvement body, PIT teams support the site leadership team and the practice by developing and testing team-based workflows, testing and spreading successful innovations at the site from one care team to another, and recommending improvements that might be shared with the rest of the ambulatory sites.

The success of the PIT teams lie in their ability to bring together individuals representing various disciplines and perspectives in an effort to effect sustainable change within a practice that reflects our journey to achieving the Triple Aim (better patient experience, better health, at a lower cost) for our patients and community.”

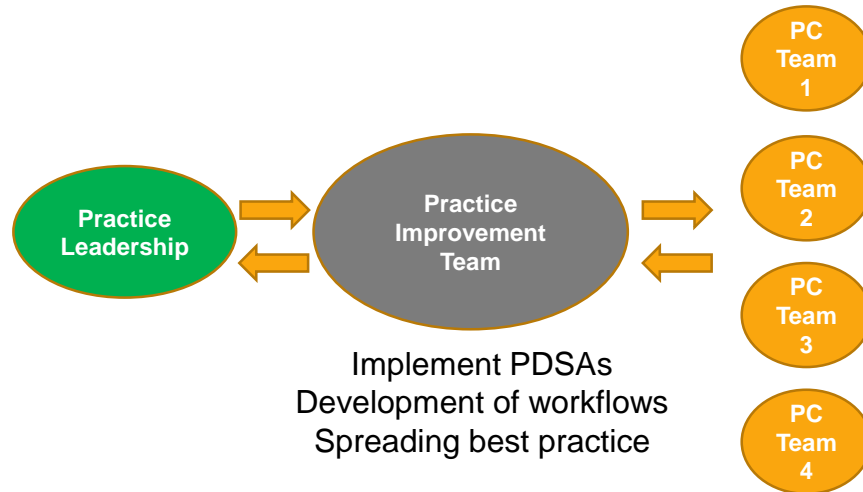
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Practice Improvement Team Goals

- Aligns with the practice leadership team’s goals and has delegated authority from leadership to be the practice’s hub of innovation
- Builds the skills, knowledge, and abilities of the practice staff /providers to do quality improvement
- Fosters a culture of innovation and collaboration so that the improvement efforts are spread throughout practice and are sustained as the new way of doing Primary Care

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Practice Improvement Team



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Nuts & Bolts – Team Composition

- Inter-professional: Members come from different professions/occupations (MA, RN, MD, NP, etc.)
- Interdisciplinary: Members represent different disciplines working together in the practice (Primary Care, Behavioral Health, Pharmacology, etc.)
- Leadership & Patient Representation: Both Leadership and Patient Partners are integrated on the improvement team

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Patient Partners

I speak for patients who cannot speak or do not have the chance to speak for themselves.

I provide the perspective of the outsider. I am not invested in "that's the way it works." I am invested in the service that's provided.

I am a kind of human project management tool. I keep the team focused on our goals.

We are at the heart of all of that our teams do to improve CHA. We help our teams understand what patients and families need, what works and doesn't work. If a team focuses on what happens in the clinic, we remind them that most of health happens at home.

We are the voice of CHA's patients, and we are heard, respected and valued.

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Nuts & Bolts - Meetings

- **Frequency:** Meetings happen often enough so that the team can collect input from members, initiate tests of change (PDSAs), review data, spread what works throughout practice
- **Facilitation:** Success of improvement team depends on conducting effective meetings with agendas, follow-up, opportunities to hear from all members

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MGH Innovation Team



- Meets weekly
- Patient Partner
- Started with the AIC Collaborative
- Facilitated by Medical Director
- Members represent all roles from all pods
- Leadership/Admin/Case Management
- Scope of Work: huddles, transition to Epic, managing prescription renewals, cancer screening workflows...everything related to team-based care

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Lessons Learned

- Leadership
- Communication & integration
- Team support
- Team members need time/opportunities to do the work
- Use of meeting tools & QI tools
- Patient Partner recruitment & engagement

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"We never know how our small activities will affect others through the invisible fabric of our connectedness. In this exquisitely connected world, it's never a question of 'critical mass.' It's always about critical connections."

-Grace Lee Boggs



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Questions/Discussion



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**Please be sure to fill out the survey
following the webinar today, thanks!**

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